BROAD AND CASSEL

ATTORNEYS AT LAW

and Gassman Law Associates, P.A.

present

Lester Perling
lperling@broadandcassel.com

Alan S. Gassman
agassman@gassmanpa.com

Florida Health Law Traps -

5 Hypotheticals and Discussion of Important Medical Structuring and Regulatory Issues

February 19, 2013 | 5:00 p.m.

Medicare and Medical Compliance Disasters – What To Do Before and After the Explosion

Monday, February 25, 2013
5:00 p.m
30 Minutes

Jeff Howard
jeffh@rayhowardassociates.com

Lester Perling
lperling@broadandcassel.com

Alan S. Gassman
agassman@gassmanpa.com

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GASSMAN LAW ASSOCIATES, P.A.

presents

ESTATE PLANNING FOR 2013 BEYOND THE OBVIOUS

Tuesday, February 5, 2013
5:00 p.m.

Alan S. Gassman, Esq.
agassman@gassmanpa.com

Thomas J. Ellwanger, Esq.
tom@gassmanpa.com

Kenneth J. Crotty, Esq.
ken@gassmanpa.com

Christopher J. Denicolo, Esq.
christopher@gassmanpa.com

Gassman Law Associates, P.A.
1245 Court Street
Clearwater, FL 33756
727-442-1200
www.gassmanlawassociates.com

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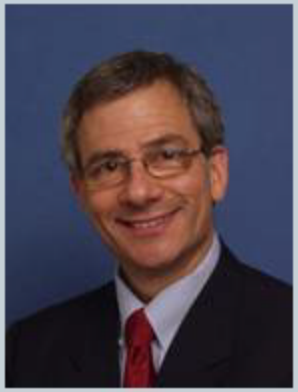
GASSMAN LAW ASSOCIATES, P.A.

presents

The Physicians Guide to the 2013 Tax Laws

Monday, February 11, 2013

5:00 p.m.



Alan S. Gassman, Esq.
agassman@gassmanpa.com

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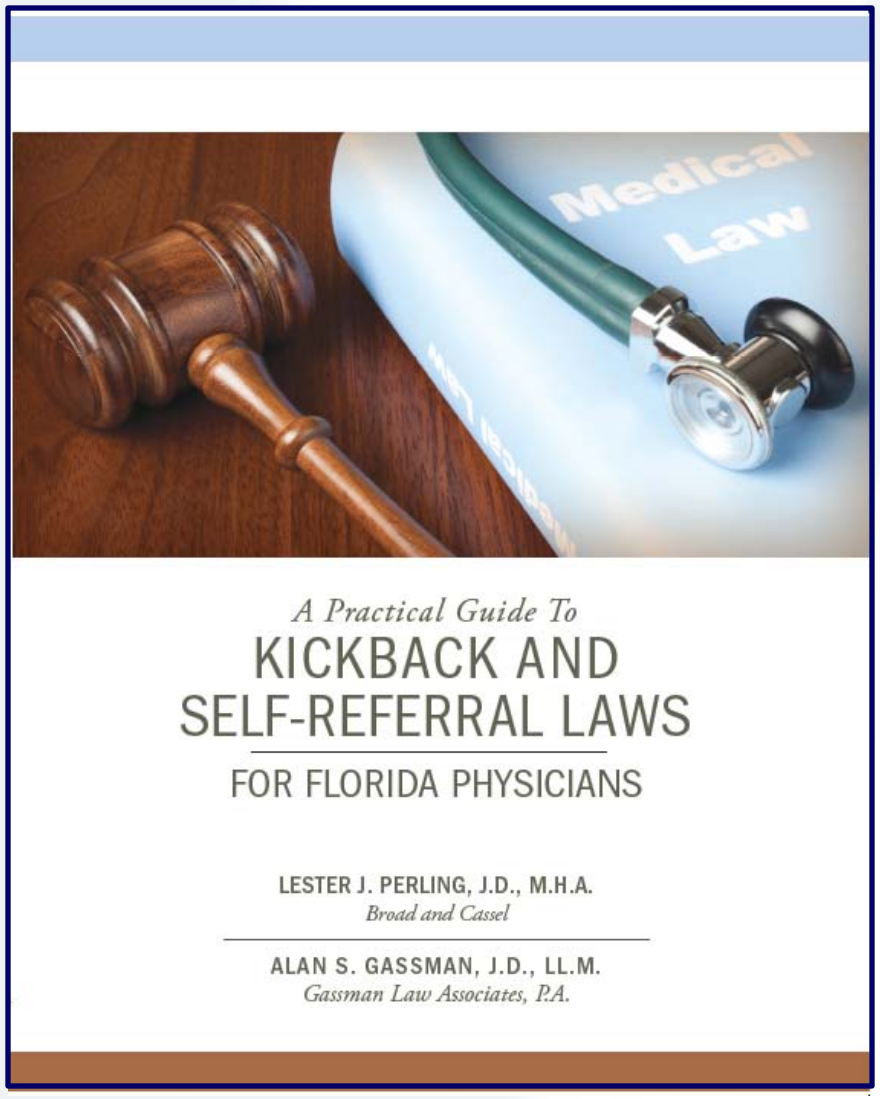

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Hypothetical #1

Your client is the administrator of a group practice. The practice has decided that because of the administrative burden and costs associated with collections, it would just waive copayments and deductibles for its insured patients but continue to charge the insurer the usual and customary charge for the service. In addition, the practice is establishing a prompt payment discount for patients that fulfill their cost-sharing obligations at the time of service. This prompt payment discount would be applied contemporaneously to the services provided to the patient.

Florida Law

- It is considered a “material omission” and “insurance fraud” for a health care provider to waive copayments and deductibles as a general business practice (Fla. Stat. 817.234(7)(a)).
- Under Fla. Admin. Code r. 69B-153.003 and 69O-153.003, “The submission or presentation for payment to an insurer, health maintenance organization or third party of a claim form, bill, or other statement for services rendered, prepared or signed by a health care provider or health care facility which does not disclose a *pre-provision of services agreement* between the health care provider or health care facility and the patient to accept less for the health care services rendered than is reflected on the claim form, bill or statement is an example of a false claim.”

Florida Law (continued)

- Fla. Admin. Code r. 69B-153.001 and 69O-153.001(5): Pre-provision of services agreement" means an agreement made or understood to exist in advance of the provision of health care services between the health care provider or health care facility and the patient to waive in whole or in part that patient's payment of the co-payment or deductible amount provided for in the contractual agreement otherwise known as the "policy", or "health maintenance organization coverage document" between the patient and the insurer, health maintenance organization or third party, or an agreement to give the patient a discount for the immediate payment of fees for services rendered.
- A health care provider is required to disclose pre-provision agreements to the insurer in accordance with Fla. Admin. Code r. 69O-153.004.

Kickback Issues

- Florida Law - It is a violation of the Florida Patient Brokering Statute (Fla. Stat. § 817.505) for anyone to solicit referrals by providing rebates, commissions or bonuses. So if the waiver of the copayments and deductibles is considered inducement for referrals, there could be a patient brokering issue here.
- Federal Law – The federal Anti-kickback statute is a criminal statute that prohibits the exchange of anything of value, in an effort to induce (or reward) the referral of federal health care business (42 U.S.C. § 1320a-7b).
  - There is a safe harbor for waivers of beneficiary coinsurance and deductible amounts but it only applies to inpatient services (42 CFR § 1001.952(k)).
  - However, HHS-OIG opined in its 2008 advisory opinion that prompt payment discounts are generally allowable as long as the discount is not a means to induce patients to self-refer. *Advisory Opinion 08-03* (Feb. 8, 2008), https://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-03A.pdf.

Hypothetical #2

Your client is a solo physician practice. A police officer comes to the practice and asks questions about the treatment provided to a particular patient. The police officer explains that he is conducting a preliminary investigation involving that patient and explains that he needs to know what medication the physician has prescribed to the patient. The police officer does not have a court order or subpoena for the medical records. How should you advise the physician to respond to the police officer's request?

Federal Law

- HIPAA: The Privacy Rule permits health care providers to comply with court orders or court-ordered warrants, subpoenas or summons, grand jury subpoenas, and administrative summons or civil investigative demands. (45 CFR 164.512(f)(1)(ii)). *Cannot turn over PHI if the police officer does not have the appropriate order*.
- In the case of an administrative summons or civil investigative demand, if de-identified information cannot reasonably be used, the information sought must be relevant and material to a legitimate law enforcement inquiry, and the request must be specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought.

Florida Law

- Allows medical records to be furnished in any case or criminal action, unless otherwise prohibited by law, upon the issuance of a court order or subpoena from a court of competent jurisdiction. The party seeking such records pursuant to a subpoena must give proper notice to the patient or the patient's legal representative. (Fla. Stat. 456.057(7)(a)).
- Search warrant?
  - There is case law to support that medical records can be obtained through a search warrant allowing law enforcement to seize records so long as those records remained sealed pending notice to the patients. *See* State v. Rattray, 903 So. 2d 1015 (4th DCA, 2005).

Disclosure of Substance Abuse and/or Mental Health Records?

- Federal Law – Under 42 U.S.C. § 290dd-2, records pertaining to substance abuse treatment are deemed confidential. These records can be disclosed if authorized by a court order. Court order must be issued if "good cause" is shown. Good cause means that disclosure is require to "avert a substantial risk of death or serious bodily harm." 42 U.S.C. § 290dd-2(b)(2)(B). Absent such court order, these records cannot be used to "initiate or substantiate" any criminal charges against a patient or to conduct an investigation of the patient.
- Florida Law – Mental health records are confidential (Fla. Stat. § 394.4615). A specific court order is necessary for the release of this type of information. Similarly substance abuse records are also deemed confidential (Fla. Stat. § 397.501(7)) and can only be released to law enforcement personnel under very limited circumstances.

Hypothetical #3

You represent a physician practice that is enrolled in the Medicare and Medicaid programs. During a routine internal audit the practice's billing manager discovered that certain claims submitted to and reimbursed by the Medicare and Medicaid programs were "upcoded." The billing manager brings this error to your attention. What are the practice's obligations under state and federal law?

Federal Law

- - Liability under the Federal False Claims Act (31 U.S.C. § 3729 et. al).
- - Reporting and Returning Overpayment (added by the Affordable Care Act):
    - "If a person has received an overpayment, the person shall (A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and (B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment." 42 U.S.C. § 1320a-7k(d)
    - 60-day deadline to report and return overpayment: "An overpayment must be reported and returned under paragraph (1) by the later of (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable." 42 U.S.C. § 1320a-7k(d)
    - Any overpayment that is retained after the deadline for reporting and returning the overpayment is considered "an obligation" for purposes of the federal False Claims Act liability under 31 U.S.C. § 3729(b)(3).

Florida Law

- Liability under the Florida False Claims Act (Fla. Stat. § 68.081 et. al).
- Medicaid requires providers ensure that the claims that it submits to the Medicaid program are true and accurate (Fla. Stat. § 409.913). Each day that the provider retains a payment to which she is not entitle, constitutes a separate and sanctionable violation (Medicaid Provider General Handbook, p. 5-5). The Medicaid agreement also requires providers to refund any monies received from the Medicaid program in error or in excess of the amount to which the provider was entitled within 90 days of receipt.

Hypothetical #4

You represent a hospital that has a lease rental arrangement with an orthopedic physician's practice. Under the arrangement, the physician pays the hospital a fair market value monthly rent to lease office space from the hospital. The rental agreement expired 8 months ago but the physician has continued to occupy the space and continues to pay the rental amount outlined in the expired agreement. What are the implications under the STARK law?

STARK Law

- The lease exception to the STARK law (42 CFR § 411.357(a)) requires:
  - That the agreement be set out in writing, signed by the parties and specifies premises covered;
  - The space rented does not exceed those that which is reasonable and necessary for legitimate business purpose of the rental;
  - Term must be for at least one year;
  - The rental charges over the term of the agreement must be set out in advance;
  - The rental charge must not be determined in a way that takes in account the volume or value of referrals or business generated between the parties;
  - The agreement must be commercially reasonable even if no referral were made between the parties;
  - A month-to-month holdover is allowed for a period of 6 months.
- In this hypo, the fact that the lease agreement expired more than 6 months ago means that there is a STARK issue.

STARK Law (continued)

- Application of temporary non-compliance provision (42 CFR § 411.353(f)) for arrangements that have fallen out of compliance with STARK. A 90-day period of non-compliance is allowed if [1] the arrangement was in compliance with STARK for at least 180 days prior to when it fell out of compliance; [2] the arrangement has fallen out of compliance for reasons beyond the control of the entity and the entity took prompt steps to rectify the noncompliance; [3] the financial relationship does not violate the Anti-kickback statute or other state/federal regulations.
- STARK Self-Disclosure Protocol (Section 6409, Affordable Care Act).
- Potential violations of the federal and Florida FCAs.
- What if the physician stopped paying rent?

Hypothetical #5

Your client is a physician practicing with a group practice. Your client's first cousin is a minority owner of a home health agency. Your client and the other physicians in the group refer patients to the cousin's home health agency for care. In addition, your client's wife is a specialty physician who owns an independent practice to which your client and the other physicians in the group refer patients. Are these referral problematic under state and federal law?

Federal Law

- "DHS" and "immediate family" are defined in 42 C.F.R. § 411.351.
  - Home health services are DHS but a first cousin is not considered "immediate family" and thus referral are not barred by the STARK law.
  - DHS referrals to the wife's practice pose a STARK problem because she is considered immediate family.
  - As far as the other physicians in the group practice are concerned, their referrals are not imputed to the physician unless the physician "directs the group practice" (for example, if he is the medical director of the group practice) [42 CFR § 411.353].

Florida Law

- The Florida Patient Self-Referral Act applies to DHS and non-DHS services (Fla. Stat. § 456.053).
- Referrals made to the first cousin would be allowable but all referrals made to the wife's practice would violate Florida law because such referrals would be considered self-referrals.

Questions?

Lester J. Perling, Esq.
Broad and Cassel
Fort Lauderdale, FL
lperling@broadandcassel.com

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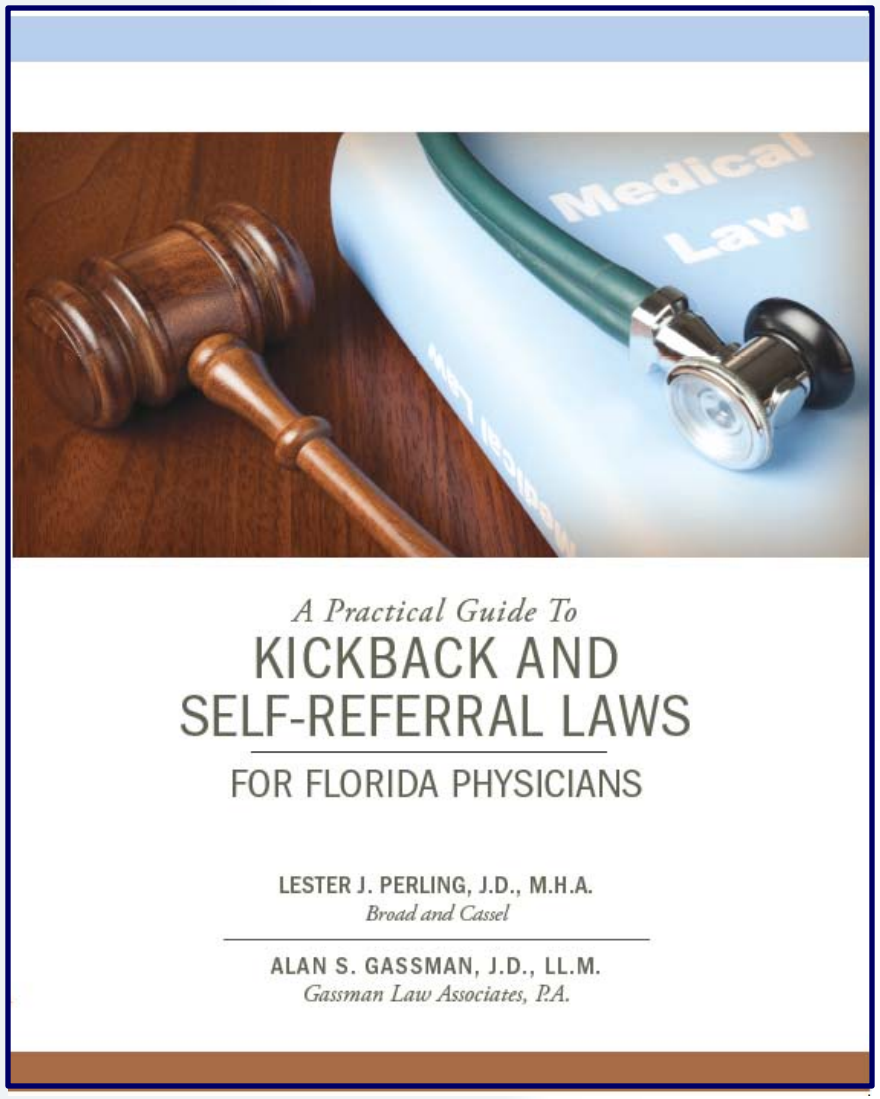

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